Eliminating Disparities in Perinatal Health/Border Health Technical Assistance

MCHB DHSPS Webcast

January 6, 2011

JOHANNIE ESCARNE: Good afternoon. On behalf of the division I would like to welcome you to this webcast titled "Eliminating Disparities in Perinatal Health/Border Health Technical Assistance". Before I introduce our presenters today, I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentation. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. A 12 second delay typically provides optimal performance for the audience. We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right space of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning beneath the video window. At the end of the broadcast, the interface will close automatically and you'll have the

opportunity to fill out an online evaluation. Please take a couple minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

We have several presenters with us today. Our first presenter is Karen Hench, the director of the Division of Healthy Start. Also joining us are Beverly Wright, Healthy Start team leader, Benita Baker, senior project officer and David de la Cruz director of policy and program development. We'll defer questions to the question and answer session following the presentation. However, we again encourage you to submit questions at any time during the presentation. If we don't have the opportunity to respond to your question during the broadcast, we will email you afterwards. Without further delay, we will again welcome our presenters and the audience and begin our presentation. Karen.

KAREN HENCH: Thank you, Johannie. Again I'm Karen Hench, the interim director for the Division of Healthy Start within the Maternal and Child Health Bureau and the Health Resources and Services Administration and I want to welcome you to "Eliminating Disparities in Perinatal Health/Border Health Technical Assistance" webcast. This is for organizations that are interested in applying for Healthy Start border health grant announcement number HRSA11-018 and I'm very happy that you're interested in joining the Healthy Start family and applying for a program that has been in existence for 20 years now to address the factors that are associated with infant mortality and other adverse maternal and infant outcomes and I am happy to be joined here by so many of

the Healthy Start staff who are going to address various aspects of the application process. Bev.

BEVERLY WRIGHT: I'm Beverly Wright the team leader for Healthy Start. Next slide, please. This presentation overview, we'll be answering the questions what is the Healthy Start program, what are the current funding opportunities, who is eligible to apply, what are the deadlines for applying, how does my organization apply, what are the critical requirements that need to be addressed in my application, how is the application reviewed? Next slide, please. What can Federal funds be used for? Are there restrictions on what Federal funds can be used for? Are there other Federal policy requirements applicants should be aware of? Contacts for more information and other resources. Healthy Start's role -- next slide, please.

Healthy Start's role in reducing disparities -- in addressing disparities include to reduce the rate of infant mortality, to eliminate disparities in perinatal health. To implement community based interventions to improving and support perinatal delivery systems in project communities. To make sure every participating woman and infant gains access to the health delivery system and followed through the continuum of care to provide strong linkages about the local and state systems. The slide shows us where we rank internationally in the 2002 amongst these -- the industrialized nations. Our infant mortality rate in 2002 was 7 infant deaths per 1,000 live births. While it's an improvement from many years ago, it is still not as good as Iceland, I believe that is that has 2.2 or as good as Switzerland that was 4.5. So we have a ways to go in order to

bring our infant mortality in line with the rest of the industrialized nations. This slide shows where we are as far as the United States. From 1995 to 2004 by race. We can see that African-Americans or non-Hispanic Blacks have the highest rate of infant mortality even in the year 2004. Next slide, please.

This one shows where -- this slide shows where these infant deaths are the highest and as you can see from the slide, most of them are in the southeast states like Mississippi, north and South Carolina, Tennessee. This is where we have the highest infant mortality rates during the years of 2002 to 2004. Next slide, please. This shows how -- where the Healthy Start project area sites are. If you take a look at -- if remember what the infant mortality slide looked like and what this slide looks like, you can see the majority of the Healthy Start projects are located in areas where there is the highest infant mortality rate and the greatest need. Next slide, please.

Healthy Start was established as a presidential initiative in 1991 to improve the healthcare access and outcomes for women and infants, to promote health behaviors and combat the causes of infant mortality. There were 15 sites between 1991 and 1997. These were the 15 original sites. Seven sites were included in 1994 to 1995. Those sites remain with us today and they've been in Healthy Start for the last 20 years. We'll be celebrating our 20th anniversary this fall. In 1998, Congressional language asked us to have exciting sites serving as Resource Centers. 20 of the original 22 sites became mentoring sites and were mentoring sites from 1998 to 2001. Also in that period we brought about 50 to 76 new communities. What lessons? Next slide, please.

What lessons has Healthy Start learned? We've learned through a national evaluation, internal assessment by a national consultant and through the secretary's advisories Committee on infant mortality. The overarching conclusions included strong outreach and case management models. Close link to clinical care. Implementation of evidence-based practices, and consistency in program implementation in time and across program sites. Next slide, please.

Where should the focus be? Services should begin in the prenatal period and extend beyond the postpartum period through the conceptual period. It is concluded to the next pregnancy. Healthy Start sites follow the woman from pregnancy to two years post delivery. We also have a few sites that start in the pre-conceptual period before a woman becomes pregnant. Healthy Start's authorizing legislation is Title III section 330. To make grants for project areas with high annual rates of infant mortality. Consideration in making grants -- next slide, please. Are factors that contribute to infant mortality such as low birth weight, the extent to which applicants for such grants facilitate a community based approach to delivery of services and the comprehensive approach to women's health care to improve perinatal outcomes. Next slide, please.

The extent to which applicants for such grants facilitate a community-based consortia of individuals and organizations including but not limited to agencies responsible for the administering the grant programs under Title V of the Social Security Act. Consumers

of project services, public health departments, hospitals, health centers under section 330 and other significant sources of healthcare services. Next slide, please.

Also considering in making grants is special projects. Nothing in paragraph two shall be construed to prohibit the secretary from awarding grants under subsection A for special projects that are intended to address significant disparities in perinatal health indicated in communities along the United States/Mexico border or in Alaska and Hawaii. This particular grant program -- this particular grant request is under this section because we're looking at United States and Mexico border. There are 62 miles along Texas, New Mexico, Arizona and California. And that's the area that is eligible for applying for these grants. We must have a consumer -- community consortium of individuals and organizations including but not limited to agencies responsible for administering the Block Grant program under Title V of the Social Security Act. Consumers of project services, public health departments, hospitals, health departments, I'm sorry, health centers and other sources of healthcare. Next slide, please. Collaboration. Highlights of section 338 in Healthy Start include partnerships with state-wide systems and other community services funded under the Maternal and Child Health Block Grant. That's Title V program. Healthy Start -- next slide, please. Currently Healthy Start start is in 38 states, the district of Columbia, Puerto Rico, we serve indigenous populations and border communities. Next slide, please.

Once again you see where the Healthy Start sites are. Next slide, please. Eliminating disparities in perinatal health to border, Alaska and native Hawaiian communities. Two

grants whose project ends this year Mmay 31st, 2011. There are two that include project period will end next year May 31, 2012 and three will end in to 14. To give you the scope of the program we have 97 communities that are in other states. 13 grantees whose project period ends in 2015. Six grantees whose project period ends in 2012 and 78 grantees who project period ends in 2014. Next slide, please.

This eliminates disparities in perinatal health. Summary of the funding. It's a five-year project period, maximum of 750,000 annually for new projects. Not 750 for the five years, it's 750 each year for five years. Healthy Start grantees, which are considered competing continuation may only apply for the amount up to their current funding level. And anticipated start date is June 1st, 2011. Next slide, please. David will take it from here.

DAVID DE LA CRUZ: Okay, I'm going to talk a little bit about eligible applicants, who the eligible to apply. Applicants that are not currently funded through Healthy Start or current Healthy Start projects applying for new service area are considered a new applicant and should check the new box on question 8 on SF424 face page. As Beverly said, this grant competition is for those projects along the U.S./Mexico border, 62 miles or located in Alaska or Hawaii. Next slide.

Now, to be an eligible applicant you need to meet these criteria. We'd prefer if you met this one, for 2005 to 2007 the proposed project area must have one or more racial, ethnic or other disparate group with a three year infant mortality rate of at least 10.14.

Infant deaths per 1,000 live births. That's 1 1/2 times the national average. Again, we need it to be for 2005 to 2007, that three-year period no other three-year average will be accepted. Next slide.

Now, we understand that many of these communities may not be able to meet that criteria or may not be able to have the data on infant mortality rate. Therefore, for the eight 67 border communities there are other ways that you can be eligible. So if you can't provide data on infant mortality, then you need to meet three of the following criteria. Again, for 2005 to 2007. You need to have the percent of women of childbearing age who are uninsured is greater than 35%. The percent of children 0 to 2 with a completed scheduled immunization is less than 60%. Percent of infants in the bottom 10% on the growth weight chart is greater than 25%. And percent of children under 18 years of age with a family income level below the Federal poverty level exceeding 19.9% for 2000. So that's the one that is not for 2005 to 2007. If you choose to use that criteria, you must identify the source of where you got that information. Next slide.

Now, again, more criteria that you can use. Again, you need to only meet three of these. Percentage of pregnant women with anemia or iron deficiency is 20% or greater. Percent of pregnant women entering pre-natal care in the first trimester is less than 80%. Births to women who had no prenatal care at all 2%. Women who had fewer than three visits is greater than 30% from the years 2005 to 2007. Next slide.

Now, if clinical data are being used, you need to provide a data source. And if you are using clinical data, again, it needs to be for 2005 to 2007. And you need to give us both the numerator and the denominator plus the final calculation. It is not enough to give us the final number. You need to give us the raw numbers. Next slide.

So if you're a competing applicant, that is if you're currently funded Healthy Start project whose project period ends May 31, 2011, you are considering a competing continuation applicant. Next slide.

You also need to demonstrate a linkage to state Title V. Beverly talked about this a little bit. We hope and expect a close relationship between your agency and the state Title V. A lot more than just a letter of support. We also -- it is also mandatory that you have an existing consortium or detailed plan to start a consortium. We'll talk about that more later. Some examples of eligible applicants. They can be a consortium or network of providers, a local government agency, tribal governments, agencies of state governments, multi-state health systems or special interest groups serving a community area or faith and community-based organizations. Next slide.

Now, there will be a preference for this competition so let's take some time to talk about what that means. The U.S. Senate report that accompanied the relevant authorizing legislation that Beverly has already discussed, urges HRSA, the Health Resources and Services Administration to afford a funding preference to some applicants. Those

applicants that receive the preference will be placed in the more competitive position among applicants that can be funded. Next slide.

We'll talk more about this. However, whether or not you're given a preference, your application will still be reviewed and scored just like everyone else. There is no difference in the review process, the review as it relates to your preference eligibility. Next slide.

Now, who will get the preference? Preference will be given to current and former Healthy Start grantees with expiring or recently expired project period. So a current Healthy Start grantee is defined as a grantee receiving Healthy Start funds for the project period that started June 1st, 2007 and ends may 31st, 2011. Next slide.

Now, a current Healthy Start grantee with neither an expiring nor recently expired project period may still apply to serve one of these new communities. However, only one applicant per project area will be funded and you will not be given preference -- you will not be given a preference. You must, however, meet all other eligibility criteria. Remember, this is just for a border competition. Next slide.

The way to apply for this grant opportunity is electronically. HRSA is requiring applicants for the funding to apply electronically through grants.gov. Next slide.

HRSA will not accept any paper applications without a waiver from the Division of Grants Policy. If you need a waiver, you need to submit in writing a request for an exception to submit electronically to GDP clearing at HRSA.com. Provide details as to why you are technologically unable to submit your application electronically through the grants.gov. There are several resources for religious non-discrimination and other faith and community organizations. Also on grants.gov there are standard forms provided. You will need a DUNS number and a Central Contractor Registry in order to apply through grants.gov. Also there are key facts about grants.gov. You can search HHS opportunity by date categories or eligibility and you can find each current and archived HRSA opportunity by program area, CFDA or announcement code, name or deadline. On grants.gov, their resources section provides access to useful information. There is links. You can take advantage of outreach materials and training materials to help you become familiar with the grants.gov process. And you can also download the download software page will explain how to easily navigate on the site and complete the applications. Next slide, please.

Grants.gov has streamlined their process of finding and applying for Federal grant funds. The process usually takes about three to five days to complete the registration process. If you have not -- you don't have to register on grants.gov if you just want to search for various opportunities. But if you do want to apply for a grant, you must register your organization. Next slide, please.

There are two ways to register on grants.gov. You can register as an individual or register as an organization. If you -- the majority of you will probably be registering as an organization so the steps that follow are what you should do. Next slide, please. You should register your organization, register yourself as an authorized organization representative, otherwise known as AOR, and get authorized as AOR by your organization. You will need a DUNS number, as I've said before, in order to complete your application or the registration process. If your organization doesn't have one, then they need to go to fed gov.DMV.com/web form to get a number. It takes about one day. You can get it the same day. Also at mentioned before your organization has to be registered with the Central Contractor Registry, CCR. If you're not registered, you can go to www.CCR.gov. You won't be able to move on until you have this number. And that takes about two days in order to complete that registration process. After you've done -- completed the DUNS number information and the CCR information, you can create a username and password with ORC, the grants.gov service provider. Of course, you'll need to use your organization's DUNS number to access the ORC website at apply.grants.gov/ORC register and that can be done the same day. Register with grants.gov to open an account using the username and password you received from ORC. Both registration at ORC and grants.gov can be done in the same day. Your E-business point of contact at your organization must respond to the registration email that you'll receive from grants.gov and log in at grants.gov to authorize you as an AOR. Note that there can be more than one AOR per organization. This takes about one to two days. You have the ability to track your AOR status at the applicant home page of grants.gov by logging in with your username and password. There will be

additional forms to upload as part of your electronic submission. One downloading from www.hrsa.gov/grant or contacting the HRSA grant application center. It must be earmarked and mailed before the deadline time. It's 8:00 p.m. Eastern standard time. We ask that you please try to get your application in at least 24 hours prior to the deadline. This will give you time if you have any processing issues or uploading issues. It gives you time to get the application in, so don't wait until the last minute because they will close that portal.

Okay, so next slide. We'll now start to talk about some of the critical requirements that are needed to be addressed in your application. Next slide.

So before we begin with that, let's talk a little bit about Healthy Start as a program and the logic model that we use to describe the process. So on the left-hand side you'll see we start with the context of the community and the target population that we're serving. We deal with everything from the demographic socialio economic status. Women's reproductive history. With the community we address characteristic, healthcare system, state and local policies and then even higher than that the national and state sort of the economic conditions, the policy issues that may affect our population and investment in Maternal and Child Health. With that we implement the Healthy Start program. It's made up of a number of core services including direct outreach and client recruitment, case management, health education, interconceptual care. The staffing, the organization itself, the activities and roles they play. And then we also do some system building. We have talked a little bit about the community consorta and the sustain built

plan. That's Healthy Start. As you implement the program over time we anticipate seeing some intermediate outcomes. So in the service area, some greater utilization of the healthcare system, more referrals of the target population to other healthcare providers, a change in the service intensity, behavioral changes and increased number of people with a medical home. Health systems changes would include coordination and collaboration, increased capacity, new services being offered in the community, those services being offered in a culturally competent and sensitive manner. And also perhaps changing community values and areas of concern. Now, as more time goes by, we expect some longer-term outcomes including reduced disparities and access to and utilization of healthcare. Improved consumer or program participant voice, and improved local health system care. That hopefully would lead to a Healthy Start population changes. Better birth outcomes, maternal health being affected. Interpregnancy and interdelivery interval birth spacing. All leading to the ultimate outcome of reduced disparities and health status for the target population. Next slide. So we will shortly be starting to talk about these core services and core components a little bit more. But let's give you a little background or a little foundation here. We'll first start talking about the Healthy Start services. So on the left-hand side you'll see the first step we do is outreach to the population. The population is made up of high-risk pregnant women, high-risk interconceptual women. Other women of reproductive age. And also fathers and male partners. Now, once we've identified the people we want to serve, we conduct a risk assessment on them. And based on that information they either go into Healthy Start case management, whether that case management is either regular or intensive is determined, or it's possible that they will just be given some more

general health information and referred on to other healthcare agencies in their community. However, if they do become a Healthy Start client, as we move right you'll see coordination of care, Healthy Start coordinates the system of care or the types of care our participants get, both medical and social aspects of it. We also realize that just by getting them a doctor's appointment or nurse's or healthcare appointment isn't enough. There are times when they may need some enabling services such as transportation or perhaps childcare is an issue that prevents them from getting care. They -- we also will help them with eligibility assistance weather it's Medicaid, WIC or other types of services and for many of the populations that you may be serving along the U.S./Mexico border you also may need some translation or interpretation services. Also a very important aspect or component of Healthy Start is health education. That can be informal health education that occurs during a regularly-scheduled health class or health appointment or can be as formal as a health class. So some of the services that we provide is HIV counseling. Bacterial testing and treatment. Perinatal depression, family planning, smoking cessation, nutrition counseling and WIC. Breastfeeding education, substance abuse treatment and violence prevention. For the women -- for the infants or toddlers we conduct home visits, well child visits, immunizations, early intervention when they're needed and we can provide supplies or equipment diverse like car seats, cribs, anything that would help the baby be healthy. Some of the disparities in pregnancy outcomes we address pre-term labor, low birth weight, congenital malformations, in infants we address SIDS, injuries, infections, in women also infections, HIV, STD, perinatal depression and short interpregnancy intervals. Reduced disparities in Maternal and Child mortality, healthy babies, healthy

families. Next slide. Now, along with service components we have a number of systems components. You'll see at the bottom of the slide all of these are done in conjunction with the community. The community needs to be actively involved in all aspects of Healthy Start. The first thing that you all will be doing is conducting a needs assessment and from that needs assessment you will be setting your priorities of what you plan on addressing in your program. Your local health system action plan so your consortium and your work with Title V are the ways you'll start to actually expand your existing health system. We expect you or hope that you would create new services, develop service provider networks, coordinate with existing services and resources, influence policy, conduct ongoing needs assessments. You shouldn't just do one every five years as you start to apply. Develop your sustainability plan, Federal funding is not guaranteed every year, so you should be planning at all times that for other sources of funding so that the good work that you start with Healthy Start can continue well beyond Federal funds. You should establish coordination mechanisms and communication between system-level planning and service-level implementation. All that should lead to the system outcomes, increased service capacity, increased participant satisfaction, increased cultural, financial and structural access to care. Increased children, women and families with a medical home and those should feed up to a larger system changes, increased integration of prenatal. Primary and mental health services. Perinatal depression, policy changes at a local and state level. Sustained improvement in access to care and service delivery system. Next slide. There are several requirements that -- several sections of your application that you will need to include. So we'll go over each in more detail. The need, the response, evaluation, impact, resources and capabilities

and support requested. So let's go over them one by one. Next slide. First we'll start with need and that's worth 20% of your score. Need is the extent to which the application describes the problem and the associated contributing factors to the problem. So you will need to develop a plan -- a plan of activities and ways you are going to address these problems. So the first step is to identify the problems and then how well is that -- you'll be scored on how well that plan is developed that will address the disparity activities in your community. Next slide. So you'll need to do three things. You'll need to describe the community, need to identify the needs of the community and then you'll need to describe a plan on how you will address those needs. So I should say here, though, that Healthy Start is what we call a gap-filling program. You are not to use Healthy Start funds to supplant other funds or other activities. If those activities or those funds are already in your community, they should stay there and you should just go into the community and work in the community and work with these other agencies and other organizations to enhance them to strengthen them and to expand them. Healthy Start is the payer of last resort. So you need to be sure that you are strongly linked to what is already in the community. Next slide. So you'll begin by doing a community assessment and the community assessment must describe the following. The current assets and resources of your community, the current needs of your community, the service area of your community, the service area of the project, the target population that you will be serving and the comprehensive and quality of service delivery system for your target population. Next slide. So the -- this slide again stresses the importance of including all partners and all other agencies and organizations in your community, whether they be prevention, primary, specialty care,

mental health, substance abuse services, HIV/AIDS, dental. The other thing you need to do and that you'll be scored and judged is how well have you linked to these other agencies and how strong is your referral process to these other agencies? That is, if you find that the people you're serving, one of your clients needs to be referred to one of your partnering agencies, what is the process, the formal process that you'll go about referring them to that agency and then also how will you follow up to make sure that referral was completed? So next slide Bev will take over the next.

BEVERLY WRIGHT: Now to establish your community needs assessment the next piece is to respond with the core service intervention. The response should include the extent to which the proposed project responds to the purpose included in the program description. The clarity of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities scientific or other described in the application are capable of addressing the problem and obtaining the project objectives. It is here where you start to do your project plan and determine what your goals and objectives are going to be in response to the application guidance, okay? And we look at the extent of the project objectives incorporated with specific Healthy Start program competition purpose, eliminating disparities and are measurable, logical, appropriate in relation to the scientific problems and the interventions identified. Next slide, please. Objectives and indicators. You need to identify project objectives which are responsive to the goals of the program, you need to develop -- the project objectives must include at a minimum OMB improved performance and outcomes measures that we'll go over a little later. The statements must be clearly described what is to be

achieved. When and the extent of the achievement on the target population. Each objective must include a numerator, denominator, a time frame, data source including year and baseline data. Healthy Start annual key measures to program participants is the percentage of program participants of MCH-supported programs who have a -- who have a prenatal care or percentage of infant deaths among all live births. Healthy Start core interventions include for each core intervention we have a definition, we have an essential element, we have a specific requirement, we have linkage to performance measure and correlation with national evaluation. Per yodically we have evaluation of the Healthy Start programs and the interventions that you will describe must relate to this evaluation. The core services that I will talk about include outreach, case management, health education, screening and referral for depression and interconceptual continuity of care. Next slide, please. For the core intervention you must ask a series of questions that must be answered for -- that must be answered. For example, who are the target populations? Who will provide the services? Where will the services be provided? When will the services be provided? How many program participants or community participants will be served? Applicants should cull their response to each question. If you look in the guidance and I think many of you have it, each one of the sections has a number. For example, I think it's case management 1, case management II. When we're saying you must code your response to each question, you must answer the question CM1 and describe your response. The core intervention of outreach, how will your program conduct and provide outreach and recruitment to the two levels of Healthy Start participants? Program participants and community participants. Specifically tell if these activities will be conducted by the staff

employed by your Healthy Start program, okay? Which is the who. If they will be conducted by a subcontractor or other types of provides. The intake and enrollment processes and who supervises that. The staff or a local provider or subcontractor including the strategies you will use to increase awareness and name recognition of your Healthy Start program in the target community. This is CS 1,. The definition of outreach that we have -- next slide, please. The provision of case finding services that actively reach out into the community to recruit and retain clients in the system of care. The purpose is to identify, enroll and retain clients most in need of Healthy Start services. So case management our definition is the provision of services in a coordinated culturally sensitive approach. Monitoring, facilitation, follow-up or the utilization of needed services. The purpose is to provide coordinated services for multiple providers to assure that each family's individual needs are met to the extent the resources are available and the client agrees with the scope of planned services. In case management you must always exclude the client as -- actually in all of Healthy Start in each factor, in each component you must include the participants, the program participant as part of the plan services. Services will only work if people have buy-in. The essential elements of case management are multidisciplinary team that includes outreach workers, nurses, social workers, paraprofessionals, nutritionists and healthcare providers. Service delivery including the home. A broad scope of services included indication, prevention and intervention. Proactive partnerships between case managers, family, service providers and the community. Individualized needs assessments and service plans developed with the community and service intensity that matches every level of risk. The definition of health education is health education

includes not only instructional activities and other strategies to change individual health behavior but also organizational efforts, policy directives. Economic support, environmental activities and community-level programs. The purpose of health education campaign is to disseminate information with the goal improving an awed yen's knowledge regarding a particular area of health promotion. Public information and education campaign are essential elements, provider training of healthcare workers, consumer and client education packages, collaboration with experienced community organizations, feedback process of the evaluations, training and education and opportunities for education and training to enhance the development of the community. These are all elements of health education and one it's not a single one, but an integration of all of these activities that make up a health education program within Healthy Start. Another essential component of Healthy Start is screening for depression in the perinatal and postpartum period. Depression is considered a depressive disorder defined as illness that involves the body, mood and source. It effects the way a person eats and sleeps, the way one feels about oneself and the way one thinks about things. Effective screening and referral for treating includes performing a skilled screening. Successfully engage women who are experiencing depression to appropriate mental health services. Community education on the impact of perinatal depression and resources available to women and their families. We as Healthy Start community go out to the communities throughout the surrounding communities and educate women about perinatal depression. That's an expectation of Healthy Start. We have found that by doing this, we make people well aware that it's not just baby blues that women can have a problem with depression and our goal is to identify the women that have -- at risk for

being postpartum depression and link them with the appropriate services. So we screen, we perform skilled assessment and we engage pregnant and postpartum women who are experiencing depression in appropriate mental health services. Next slide, please. Interconceptual care for women. All right. As part of the interconceptual care for women. Health education and other things. What we do is we take the pieces of the case management and outreach program that -- and health education from the prenatal period and use it after the woman has the baby in the interconceptual period. The care for infants the expectations are that-out reach and case management for infants and toddlers to ensure they're enrolled in a medical home and obtaining necessary care and early intervention. That's when a child is not exactly making their milestones there are programs that go in and they provide services to the child and the parents to get the child to meet the milestones. Availability of access to a system of primary care services and appropriate screening including newborn hearing as an example as well as necessary specialty care. And health education, we provide the parents. On child development and parenting education. Benita will talk about the impact.

BENITA BAKER: We have four core system interventions that we feel have a big impact on -- may have a big impact on the success of your program and those are consumer and consortium involvement, local health system action plan, collaboration with Title V and sustainability. Impact is worth 10% of the points. When it's reviewed. So effectiveness of plan toward dissemination of project results and/or the extent to which project results may be national in scope and/or the degree to which a community

is impacted by delivery of health services and/or the degree to which the project activities and the sustainability of the program behind Federal funding. The extent to which the efforts described in the local health system action plan develop an integrated service delivery system that better serves Healthy Start program participants as well as the community as a whole. The extent to which the consortium includes or will include the appropriate representation of project area consumers, providers and other key stakeholders. So basically what that means is you should do your best to integrate consumers of the services onto the consortium or be involved in the program in soy way whether it's evaluation, focus groups, the local health system action plan is a plan that you develop a five-year plan that you develop with goals and objectives and your consortium should play an active role in developing that plan.

The plan of action of the consortium in the implementation of the proposed project plan are adequately described. Again, you are going to talk about how your consortium is structured, the racial/ethnic breakdown, the number, the various organizations that they come from, whether it's state government, CBOs. And how the consortium is going to interact with the project, staff, management, basically overall in the project. The actual or proposed communication pathways between the grantee and the consortium regarding the progress of the project are delineated. We ask that you talk about how your grant -- how you are going to communicate to your consortium what is going on with the project. That's usually done by consortium meetings being held quarterly or monthly or whatever you determine is appropriate. And you would describe that in the application how that is going to go, the information is going to flow back and forth. The

extent to which the applicant proposes to sustain the project through new or existing sources and/or acquire additional resources. The extent to which the applicant seeks to get third party, training reimbursement from non-Healthy Start program funded participants. And we ask that you detail to us how you are going to search out more funds for the project, if Federal funds are no longer available, whether you're going to try to apply for city funds, state funds, private funds, that kind of thing. I'm sorry, I haven't been saying next slide. I hope you've been keeping up with me. [Laughter] Next slide. Next slide.

Now, the community consortium consists of individuals and organizations, including but not limited to agencies responsible for administering Block Grant programs under Title V of the Social Security Act. The consumers of the project services as we talked about, public health departments, hospitals, health centers under section 330. The Mental Health Centers, homeless, rural and other significant sources of healthcare services. The consortium, we want them to galvanize the political will of the community and stakeholders to affect change in the community, change in the system, the perinatal delivery system. They provide broad based advice to grantees and then, you know, the consumer voice is very important in the delivery of service because you want to know what it is that the woman or participant or consumer is experiencing out there in the service delivery world. So you can get a general idea of some of the things that may need to be changed. The consortium, they can also mobilize stakeholders to leverage and expand funding resources. Next slide.

We've already talked about the structure in place to ensure community and consumer involvement. One thing that wasn't mentioned was within the consortium, you can have a structure where you would develop leadership skills for your consumers so they can advocate for themselves in the community. There are consortiums that should have operational guidelines such as bylaws and conflict of interest provisions.

I'm going to briefly -- I want to make sure that I'm going to talk about the local Health Systems Action Plan. I'll do it really quickly because I want -- there are some things we want to make sure everybody gets. The local Health Systems Action Plan is a comprehensive, yet realistic plan of achievable steps within the five-year funding figures that will provide the functioning and capacity of the local health system for pregnant and parenting women and their families. What happens is we accept that Healthy Start projects will look into their community, determine if there is an issue that they can work on with the consortium to make changes so it will impact the service system delivery for pregnant and postpartum women. For example, we've had people take on the use of transportation in their community. We've had consortiums take on having a -- we've had them take over maybe things like having WIC in one central location. There are other -- there are things in the community that you can do and realistically do in the five years. I'm not going to -- next slide, please. We should include all the partners. The system has in place all referral arrangements that are necessary for quality care and it's family-friendly and culturally-linguistic to the needs of the community. Targeted interventions based on gaps in the current service delivery system. Intervention should assure the system is accessible, responsive and culturally competent and the plan

should be updated annually. It should be integrated into current activities or funding sources. You can maximize -- I'm sorry, we're talking about sustainability, I'm sorry. Next slide, please. Sustainability. Integrate activity into current funding sources. Maximizes third party reimbursement, leverage other funding sources.

I'm going to go on to the next area of your application that will be scored. It's resources and capabilities. And that's worth 20% of your overall score. It's defined as the extent to which project personnel are qualified by training or experience to implement and carry out the project. So it's really your agency's capacity and experience to run a Healthy Start project. It should be mentioned that for competing continuations, those existing Healthy Start sites, your past performance as a Healthy Start grantee will also be considered. Next slide.

So in this section of your application you will talk about what you plan to do and then here you will talk about how you are qualified to do that. So we talked earlier about the plan. Your Healthy Start plan of activities. This is a section where you will show us that you have the staff, personnel and organizational experience to actually run the Healthy Start site. Next slide.

We also want to make sure that you have the ability to maximize resources, monitor your contracts and have a sustainability plan that goes beyond Federal funding. We also want to make sure you have some strong fiscal oversight. Next slide.

So again we want to make sure you have the staff that's qualified and appropriate for carrying out the interventions. And that not only you have fiscal oversight but also program oversight. So next slide.

The next slide is evaluation measures, that's 10%. That's the effectiveness of the method proposed to monitor and evaluate the project results. Quite simply we expect you to have an evaluation plan and this part will -- is that plan any good? Is that plan linked to the core systems and core service components? Next slide. Now we're going to talk about performance measures in a minute but your evaluation plans should include and should be linked to your performance measures. Also by accepting Healthy Start funding and becoming a Healthy Start project, you agree to participate and cooperate in our ongoing national evaluation. Next slide. Now, the national -- your local evaluation, your protocol should be used for ongoing quality improvement. What we don't want -- do not want is for you to use your evaluation at the end of your five-year funding to describe what you just did. Instead we really want your evaluation to be used to make or guide and make course corrections. Next slide. Here we'll talk about the performance measures. Thanks, David.

I'm going to briefly go over the performance measures because you have those in your guidance and also on the slides but as has been said earlier, under the objectives and indicators section, we ask that you identify project objectives which are responsive to the goals that you've detailed in the program in your application. You must include at a minimum the national performance measures which you'll find detailed in the guidance.

And any local programs you choose to develop. Your statements must be describe what it is to be achieved. The extent and the target population. Each objective must include enumerator, denominator, data source including year and baseline status if you have it. Two key performance measures that Healthy Start asks that all Healthy Start grantees project for. One is the percent of pregnant programs of MCHB-supported programs who have a prenatal care visit in the first trimester of pregnancy. That's performance measure 36. We ask that you project to 75% rate by the end of the project period. Also, performance measure 51, which is the percent of very low birth weight infants among all live births, we ask that you project 8.9. I believe those figures are in the guidance, I'm pretty sure they are. So the performance measures listed are -- let's see, we have 7, 10, 14, 17, 20, 21, 22, 35, 36 as I've mentioned and then we have six outcome measures, 50, 51, 52, 53, 54 and 55. And you can look those over and if you have any questions, you know, of course you can always contact us. Also, you won't be required to enter in your objectives into an electronic system until you get funded but you'll have to detail them in the application, as I've stated. Next slide.

Okay. We'll skip this slide. We've already talked a little bit about the Healthy Start system logic model. So let me move on to support requested, which is your budget. That's worth 15% of your score. Is your budget reasonable, realistic, is it justified and does it match your proposed activities? Are your administrative costs reasonable? Next slide. Here are some things that you can use your grant funds for. Your project staff salaries, to pay consultants, your data collection, hardware, software, project-

related travel and other direct expenses for the integration of administrative, clinical, financial functions. And also your program evaluation. Next slide.

So programmatically you can do the following. You can offer a more efficient and effective comprehensive delivery system. You can integrate preventive mental health, substance abuse services within an already-existing system. You can develop a shared information system among the community safety net providers. But remember, the best way to do this is to link to already-existing agencies, organizations, activities in your community. Next slide.

Now, what can grant funds not be used for? Healthy Start grant funds cannot be used to substitute or duplicate funds supporting similar activities currently. Construction, to reserve requirements for state insurance licensure or for entertainment. Next slide. Collaboration with state -- with Title V or local MCH agencies and others, the collaboration has 10%, the next part of your application. We've already talked about Title V. What we want to make sure you're not conflicting with what the state Title V agencies are doing in your community so we highly recommend that you contact your state Title V agent and review their most recent Title V Block Grant and you can coordinate with them. Next slide. Here are three things -- three ways that you can coordinate with your state Title V. I'll let you read them. Next slide.

There are a number of different ways that we will determine how you are performing. There are a number of reports and ways that we will determine your progress towards

meeting your goals and objectives including an annual progress report that you'll submit to us. The submission of your Healthy Start performance measures, your financial and demographic data you submit, as well as other data elements. Your characteristics of your participants you're serving. The risk reduction and prevention services and then also your core service systems building. Next slide.

I'll pass it back over to Beverly to wrap up.

BEVERLY WRIGHT: The core Public Health Service delivery systems through MCH is the MCH pyramid and that's what you see. That's what that slide is. Next slide, please. The application review process is the responsibility of HRSA's Division of independent review. Applications will be reviewed by an Objective Review Committee of experts qualified by training, experience in a particular field of the program being reviewed. That includes people who are familiar with border populations and who have experience with -- along the border. The application review criteria, we have pretty much showed you within the webcast how the need, the response, the evaluative measures, the impact, the resources capabilities, support requested and collaboration with Title V is outlined in your application. A Maternal and Child Health Bureau resources including the state Title V information system and there is the link, the address. Those two things. MCHB Discretionary Grant Information System if you want to look at that. It tells you about some of the performance indicators and performance measures and their outcomes. The MCH virtual library and the link to that. The MCH virtual library info is a picture of what it looks like. I would recommend that all of you go to this link. It

provides a lot of information that is free. There is a lot of past type of tools that were used by previous Healthy Start grantees and you don't have to pay for it. There is a Bright Futures material. Next slide, please, that talks about pediatrics and that's another resource that you can use. There is -- next slide, please. There is several Maternal and Child Health Bureau resources, the MCH distant learning which is this mchcom.com. I would like to tell you this webcast will be archived and available in about a week, I think it is, and you can refer back to it if you have any questions. You can always at the front of the application there is the telephone number for our division. You can speak to us and we will be happy to provide information. There is the national Healthy Start association, peristats, the www.marchofdimes.com and gives you information about infant mortality rates in communities and the Kellogg foundation has toolkits available. Our goal -- next slide, please, is to have healthy women give birth to healthy infants that lead to healthy families that leads to healthy communities and overall a healthy nation. Next slide, please. We are going to leave a few minutes for questions and answers. I'm sorry that we don't have more time but if there is any questions, we'd like to know.

>> Thank you, Beverly. We do have a couple of questions. The first question is, you asked for numerators and denominators. Does it apply only to describe the nine criteria or to data being presented in the needs assessment section as well?

>> Repeat the question.

>> You asked for numerators and denominators, does this apply only to describing the nine criteria or to the data being presented in the needs assessment section as well.
>> We're referring to when -- your performance measures data. When you present to us your objectives you're going to be presenting to us what you project your numerator and denominator will be.

>> But I would recommend if you provide us with any data in your application, that you put in parentheses what the numerator and denominator will be. That gives the people reading your application a better idea of what the population that you're talking about or, you know, how large or how small or, you know, what the problem is. I think the more you put the numerator and denominator, the better off you'll be.

>> That's particularly important in the eligibility criteria. Those data do need to be verifiable also. We need to be able to find that data ourselves and make sure that what you're submitting to us can be checked out. So the easiest way to do that is give us as much information up front so that we don't have to go searching for it and so numerator and denominator for eligibility requirements are particularly important.

>> Are there any questions in the room? There are no questions right now coming from -- actually, there are more. I need to give people a couple minutes to type quickly. Okay. In Alaska, the denominators by race, census area and age is not available due to small numbers. I would like the participants to comment.

>> Again, you know, we're sensitive to the small populations and the small target population that you may be serving. Regardless, we still need the data. We need to be able to verify that you are eligible to be a Healthy Start site and the only way to do that is for you to submit data on the target population you'll be serving. I don't know if there is anything more.

>> And if the situation is that you actually cannot access the service -- proposed project service level data, give the geographic configuration that is available. For example, if it's for a certain region within the state or for the whole state. But as David said before, it has to be data that are verifiable through the vital statistics group.

>> I think that's a really good point. Just to reiterate what Karen just said. You may not have data for your target population. If that's the case, it's acceptable to provide data for a larger group whether it be, you know, multiple zip codes, you know, a community, a county, or even in some cases it may be an entire state but we need to have verifiable data.

>> Is there a possibility that existing grantees could request a funding increase? This possibility was raised and discussed since we're currently underfunded compared to other small rural grantees that we funded other periods.

>> That's always an important question to ask and unfortunately at this time we are under a continuing resolution with the Federal budget and we're operating at our fiscal

year 2010 level and we cannot go above the funding levels that are described in the guidance. So for new applicants, there is a cap of $750,000 per year and for continuing renewals it is the rate at which they were funded at in the past.

>> I'll give them a couple more minutes. A question in the room?

>> The linkages -- [inaudible] Do they apply more to more of a clear definition or what type of linkages, what do you want?

>> Okay.

>> Before we answer that let me repeat it in case someone didn't hear it. It was more of a description of the partnership with Title V since it is a requirement.

>> What usually happens with Title V is that grantees invite them to be part of the consortium that they go through the meetings that Title V may have. We had grantee meetings and they'd bring the Title V directors with them. It doesn't necessarily have to be the state Title V, it can be the local health departments that they work with. They often have them. You just have to make it that way.

>> To support identifying what that relationship is, how you are defining it. It will be important to have a letter of support from the Title V agency in your appendix of your application.

>> There are three very specific ways that we recommend that are outlined in the guidance above and beyond what Beverly and Karen said. Partnership with statewide systems and with other community services funded the Maternal and Child Health Block Grant. Community needs assessment and plan consistent with the state Title V five year plans. I was saying earlier make sure what you're doing doesn't conflict with the state Title V plan and cooperation, integration and dissemination of information with state Title V and other community services. So, you know, you can't have too strong of a relationship with the state Title V agency. Whatever you can do. We understand that that relationship may take some time so if you don't have that relationship already in existence, that's fine, but we would like to see at least a proposed plan of how you, you know, will do that. Will develop that relationship.

>> Another question?

>> Yes, you mentioned core intervention and case management and does case management include follow up? And if it does, how does Healthy Start define a successful referral.

>> Let me repeat the question. It's regarding case management. And how we -- in Healthy Start how we look at follow-up within case management and define the success of a completed referral.

>> That's to be found in the guidance. I don't have it in front of me. What we expect is that grantees who use case management, they follow the woman, they make the referral, they make sure the woman gets there and that they get the information back, okay? That's basically where case management is. But the definition—

>> Maybe while you were searching for it. I said a couple of different times it is absolutely appropriate and we wouldn't want to see a Healthy Start project be able to have all the services a woman may need. So referrals to other agencies or organizations in the community is -- is not only appropriate but almost mandatory. So it is very important that part of her -- the management of her healthcare plan includes making sure that when those referrals do happen that the woman is seen by whoever you refer her to and that it's important that when you follow up with her in the future, that you have either a relationship with the referring agency where you can confirm that the woman was seen and the services were provided or at very least you just ask the woman to make sure they were seen. But I think Beverly has the official definition.

>> Let's see. A completed service referral is defined as a client who is either referral attending one or more sessions with the provider to whom she was referred. The provider may be within or outside of the MCH program or agency. The purpose of these referrals can either be treatment-related, which like aids or substance abuse treatment or preventive like family planning, WIC or supportive like housing, job training, transportation. That's defined in performance measure 21. Who have a completed

referral among those women who receive referrals. It's clearly defined in one of our performance measures as what a completed referral is.

>> It would fall under case management.

>> Yes, that is case management.

>> It can be outreach. Depends on how the project themselves define what is outreach and case management is. In some cases it's education.

>> Next question, as a state health department, if awarded a Healthy Start grant, you would conduct an RFP process to all eligible communities to apply. So this makes it difficult to answer many of the questions specifically since RFP applicants will need to propose their plans, etc. Any comments on this situation?

>> We don't usually do -- let me just say this. That's a unique way of providing Healthy Start services. What usually happens is the -- we have several health departments, state health departments that do this and they provide -- they provide the services in the community by way of a contract.

>> Right. That's exactly right. They don't do RFPs, they do contracts. But they're still the funded grantee.

>> So, I mean, I don't -- I think that we're talking about the same thing it's just the way this they're phrasing it. And there are various state agencies that do that. If you would like to have some information on which ones do, if you will contact us we'll put you in touch with the other state health departments that provide services to Title V and Healthy Start services.

>> The one issue. Regardless of how they'll do it, they'll still need to become an eligible applicant and need to provide data on the target area and the target population. At least that will need to be known at the time of application.

>> You might want to limit the area that you are going to provide the RFP that has the highest infant mortality rate and therefore you can use their statistics to show that this is the population you're going to reach. Or if you want to reach the African-Americans across the state, then you can use the information or -- I'm sorry.

>> Remembering it's a border competition.

>> It's a border program around the state.

>> That fall within the 62 miles or Alaska or Hawaii.

>> Right. Alaska, of course, can use the entire state and the native populations within that state.

>> I have one. How was the preference applied to the applicants? Was it automatic, was it in competitive

>> Once all the applications are scored, they come back to us and those grantees who are current grantees automatically come to the top of the listing. I think what we did is--
>> The current grantees eligible for the preference.

>> I think we might have given them -- I don't think we did at that point. We just -- we funded all of the current grantees first and then if there were dollars left over we funded somebody else.

>> Okay.

>> Are there any other questions, comments? No? Okay. Well, on behalf of the Division of Healthy Start and perinatal services I would like to thank our participants and audience and our contractor the Center for the Advancement of Distance Education from the School of Public Health at the University of Illinois Chicago for making this technology work. This webcast will be archived and available on the website on www.mchcom.com. Let your colleagues know about this website. Thank you and we look forward to your participation in future webcasts.